Dental Claim Form

See reverse for instructions

1.	2.	3. Carrier name and address
☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services Provider ID #	☐ Medicaid Claim ☐ EPSDT Prior Authorization # Patient ID #	BAI Benefit Administrators, Inc. 1250 Tower Lane • Erie, PA 16505 (814) 454-0167 (800) 777-2524

PATIENT COVERAGE INFORMATION

4. Patient name (first, m.i., last)	5. Relationship to employee	6. Sex	7. Patient birth date	8. If full time student
	☐ self ☐ child ☐ spouse ☐ other _____	M F	MM DD YYYY	school city

9. Employee/subscriber name and mailing address	10. Employee/subscriber Social Security number	11. Employee/subscriber birth date	12. Employer (company) name and mailing address	13. Group number
		MM DD YYYY		

14. Is patient covered by another dental plan? ☐ yes ☐ no if yes, complete 15-a. Is patient covered by a medical plan? ☐ yes ☐ no	15-a. Name and address of carrier(s)	15-b. Group no.(s)	16. Name and address of other employer(s)

17-a. Employee/subscriber name (if different from patient's)	17-b. Employee/subscriber Social Security number	17-c. Employee/subscriber birth date	18. Relationship to patient
		MM DD YYYY	☐ self ☐ parent ☐ spouse ☐ other _____

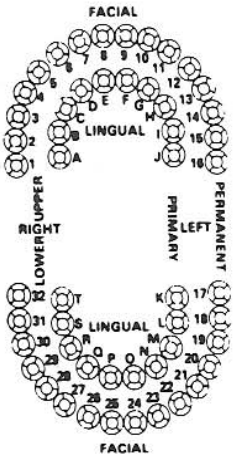
19. **I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.**	20. **I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.**
▶ _____ Signed (Patient * – see reverse) Date _____	▶ _____ Signed (Employee/subscriber) Date _____

BILLING DENTIST

21. Name of Billing Dentist or Dental Entity	30. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
22. Address where payment should be remitted	31. Is treatment result of auto accident?			
23. City, State, Zip	32. Other accident?			

24. Dentist Soc. Sec. or T.I.N. (see reverse**)	25. Dentist license no.	26. Dentist phone no.	33. If prosthesis, is this initial placement?			(If no, reason for replacement)	34. Date of prior placement
27. First visit date current series	28. Place of treatment: Office / Hosp. / ECF / Other	29. Radiographs or models enclosed?	No	Yes	How many?	35. Is treatment for orthodontics?	If service already commenced enter:	Date appliances placed	Mos. treatment remaining

36. Identify missing teeth with "x"



37. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

38. Remarks for unusual services

39. **I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.**	41. **Total Fee Charged**	
▶ _____ Signed (Treating Dentist) License Number _____ Date _____	42. **Payment by other plan**	
	Max. Allowable	
40. Address where treatment was performed	Deductible	
City State Zip	Carrier %	
	Carrier pays	
	Patient pays	